HealthAngel
Medical Insurance Claim Form

① Claim submission

- For claim submission, please complete this claim form and email/post to our company
  - Email: zurich.medical@hk.zurich.com ***OR***
  - Post: Zurich Insurance Company Ltd, Claims Department, 26/F, One Island East,18 Westlands Road, Island East, Hong Kong

Please download "Zurich HK" mobile app to enjoy a straight-through claim service for the following:
- Hospital cash benefit

② Claim acknowledgement

- Receive acknowledgment SMS and / or email in 2 working days

③ Claim result

- After submitting all the required documents, claim assessment will be completed in 14 working days with the acknowledgement sent by email/ SMS/ mail

Remarks:
1. Any claim submission must be made within ***30 days*** from the date of incident
2. For inquiry, please contact us through the following:
   HealthAngel enquiry:
   - Tel: 2903 9382
   - Fax: 2802 6633
   - Email: zurich.medical@hk.zurich.com

Claim Type

(Please ☑ the box) ☐ New claim ☐ Existing claim / submit supporting document(s), please provide the claim no. ________________________________
(Do not need to fill in "Personal details" if there is no update of relevant information)

Personal Details (*Mandatory fields)

*Policy no.____ *Insured name ____

*Insured HKID / Passport no. ________________________________ *Insured date of birth (DD/MM/YY) ________________________________

*Insured sex _____________ Insured occupation ________________ *Contact person ____
(If the same as insured person, please ignore this field)

*Contact person / Insured mobile no. ___________________________ *Contact person / Insured email address ___________________________
(Our company will send you the ***claim acknowledgement*** and ***direct credit claim settlement*** by SMS and / or email)

*Contact person / Insured postal address____

____

Our company may contact you by ***email*** to obtain additional information to process your claim, if necessary. If you would like to change the communication channel to ***mail***, please ☑ the box: ☐ By mail (If you have an insurance intermediary/agent, our company will contact you via insurance intermediary/agent.)

General Information

Are you making any other insurance claim as a result of this incident (including employee compensation, group/company medical scheme)?

☐ No ☐ Yes, please specify: Name of insurance company ______________________________ Policy no. ______________________________

Type of coverage (e.g. Medical expenses/Hospital Cash) ____

If you need to have a certified true copy of medical receipt(s) and/or medical report returned, please ☑ the box. ☐ Medical receipt(s) ☐ Medical report(s)

Payment Method

☐ ***By direct credit /wire transfer*** (Only applicable to the listed banks below and for claim amount less than HKD100,000), please provide your bank details below:

- Account holder's name (insured person OR the father or mother of the insured under 18 years old) ____
- Bank (please ☑) ☐ HSBC ☐ Standard Chartered Bank ☐ Hang Seng Bank ☐ Bank of China (Hong Kong) ☐ Other bank, please specify ___________
(Remark: If you choose to make a direct credit via "Other bank", the bank may charge you an additional transfer fee and deduct from the amount transferred.)
- Bank account no. ____

☐ ***By cheque*** (Post to Insured person's policy address or insurance intermediary; if it is absent, will post to contact person postal address, please fill in.)

Claim items and documentation

Please ☑ the relevant section(s), submit the required documents together with this form to our company. Our company may request for additional documents.

Claim items	Claim documents checklist
☐ Medical expenses caused by accident (Please fill in Section 1 (Part I)) (If there is any surgery or hospitalization, please also fill in Sections 2 and 4)	1. Original medical invoice(s) issued by registered medical practitioner / bone-setter / acupuncturists showing the insured name, diagnosis, consultation date and medical expenses 2. Copy of sick leave certificate issued by registered medical practitioner 3. Original of Attending Physician Statement completed by the attending physician (Section 4 in this form) or hospital admission / discharge summary if there was any surgery or hospitalization (applicable to Hong Kong public hospital only)
☐ Personal accident or permanent disability (Please fill in Section 1 (Part I)), Sections 2 and 4)	1. Copy of Death Certificate or Presumed death proclaimed by court (disappearance case) (applicable to accidental death claim only) 2. Copy of certificate issued by registered medical practitioner certifying the severity of injury and percentage of disablement (applicable to permanent disability claim only) 3. Copy of Police report (if applicable) 4. Copy / certified true copy of the grant of probate / Letters of Administration (applicable to accidental death claim only) 5. Original of Attending Physician Statement completed by the attending physician (Section 4 in this form) or hospital admission/ discharge summary if there was any surgery or hospitalization (applicable to Hong Kong public hospital only)
☐ Surgery/hospitalization medical fees (Please fill in Section 1 (Part I) or (Part II), Sections 2 and 4)	1. Original invoice(s) for all related medical fees 2. Copy of Attending Physician / Specialist / Anesthetist / Surgeon / Physical therapist diagnosis and/or treatment records, medical reports showing the insured name, diagnosis and consultation date 3. Original of Attending Physician Statement completed by the attending physician (Section 4 in this form) or hospital admission/ discharge summary (applicable to Hong Kong public hospital only) 4. Original invoice(s) showing the insured person's name, date of attendance, diagnosis and/or treatment record(s) and all medical expenses incurred after conducted surgery or before hospitalization
☐ Hospital cash / Surgical cash (Please fill in Section 1 (Part I) or (Part II), Sections 2 and 4)	1. Copy of Attending Physician / Specialist / Anesthetist / Surgeon / Physical therapist diagnosis and/or treatment records, medical reports showing the insured name, diagnosis and consultation date 2. Copy of Attending Physician Statement completed by the attending physician (Section 4 in this form) or hospital admission / discharge summary (applicable to Hong Kong public hospital only)

Section 1 – Details of injury and sickness

(Please ☑) ☐ This claim is caused by **accident** (Please fill in Part I) ☐ This claim is caused by **sickness** (Please fill in Part II)

Part I (The details of outpatient /hospitalization caused by accident)

Location of accident ____________________ Date and time of accident (DD/MM/YY, HH:MM) ____________________

Details of accident ____________________

Was the above accident reported to the police? ☐ No ☐ Yes, please provide copy of the police statement or police report

Injured part(s) ☐ Right leg ☐ Left leg ☐ Right upper limb ☐ Left upper limb ☐ Upper body ☐ Head Injury diagnosis ____________________

Nature of Injury ☐ Minor ☐ Moderate ☐ Severe ☐ Dead Medical fee(s) (HKD)____________________

Do you need to attend follow up treatment/consultation?

☐ No ☐ Yes, please specify how long will the treatment last / follow up consultation date (DD/MM/YY) ____________________

Part II (The details of outpatient /hospitalization caused by sickness)

Symptom(s) before admitted to hospital/consultation Date of symptom(s) first appeared (DD/MM/YY)

____________________ ____________________

Date of first consultation (DD/MM/YY) ____________________ Diagnosis ____________________

Do you need to attend follow up treatment/consultation?

☐ No ☐ Yes, please specify how long will the treatment last / follow up consultation date (DD/MM/YY) ____________________

Medical fee(s) (HKD) ____________________

Section 2 (Applicable to hospitalization/surgery claim only)

Name of hospital / medical provider ____________________

Date of surgery (DD/MM/YY) ____________ Date of admission (DD/MM/YY) ____________ Date of discharge (DD/MM/YY) ____________

	The name of doctor(s)	The address of doctor(s)
The doctor of the first consultation		
The doctor recommending admission to hospital		
The doctor consulted for the same sickness/accident		

During hospitalization period, did you have any home leave period?

☐ No ☐ Yes, please specify the period from (DD/MM/YY) ____________________ To ____________________

Do you need to attend follow up treatment/consultation?

☐ No ☐ Yes, please specify how long will the treatment last / follow up consultation date (DD/MM/YY) ____________________

Declaration and authorization

1. I / We declare that all information and particulars contained above are true and complete to the best of my/our knowledge and belief and they are made without reservation of any kind.
2. I / We understand and agree the following issues about the arrangement of my/our personal information collected or held by Zurich Insurance Company Ltd ("the Company").
   1) The personal information of customers (include policy owners, insured persons, beneficiaries, premium payors, trustees, policy assignees and claimants) collected or held by the Company may be used by the Company for the following obligatory purposes necessary in providing services to the customers (otherwise the Company is unable to provide services to customers who fail to provide the required information):
      I. to process, investigate (and assist others to investigate) and determine insurance applications, insurance claims and provide ongoing insurance services;
      II. to process requests for payment, and for direct debit authorization;
      III. to manage any claim, action and /or proceedings brought against the customers, and to exercise the Company's rights as more particularly defined in applicable policy wording, including but not limited to the subrogation right;
      IV. to compile statistics or use for accounting and actuarial purposes;
      V. to meet the disclosure requirements of any local or foreign law, regulations, codes or guidelines binding on the Company and /or its group ("Zurich Insurance Group") and conduct matching procedures where necessary;
      VI. to comply with the legitimate requests or orders of the courts of Hong Kong and regulators including but not limited to the Insurance Authority, Hong Kong Federation of Insurers, auditors, governmental bodies and government-related establishments;
      VII. to collect debts;
      VIII. to facilitate the Company's authorized service providers to provide services to the Company and /or the customers for the above purposes; and
      IX. to enable an actual or proposed assignee of the Company to evaluate the transaction intended to be the subject of the assignment.
   2) The Company may provide any personal information of customers to the following parties, within or outside of Hong Kong, for the obligatory purposes:-
      I. companies within the Zurich Insurance Group, or any other company carrying on insurance or reinsurance related business, or an intermediary;
      II. any agent, contractor or third party service provider who provides administrative, telecommunications, computer, payment or other services to the Zurich Insurance Group in connection with the operation of its business;
      III. third party service providers including legal advisors, accountants, investigators, loss adjusters, reinsurers, medical and rehabilitation consultants, surveyors, specialists, repairers, and data processors;
      IV. credit reference agencies, and, in the event of default, any debt collection agencies or companies carrying on claim or Investigation services;
      V. any person to whom the Zurich Insurance Group is under an obligation to make disclosure under the requirements of any law binding on the Zurich Insurance Group or any of its associated companies and for the purposes of any regulations, codes or guidelines issued by governmental, regulatory or other authorities with which the Zurich Insurance Group or any of its associated companies are expected to comply;
      VI. any person pursuant to any order of a court of competent jurisdiction; and
      VII. any actual or proposed assignee of the Zurich Insurance Group or transferee of the Zurich Insurance Group's rights in respect of the policy owners.
   3) All customers have the right to access to, correct, or change any of their own personal information held by the Company by request in writing to the Company's Personal Data Privacy Officer at the address below.

      Personal Data Privacy Officer
      26/ F, One Island East
      18 Westlands Road
      Island East
      Hong Kong

   4) In accordance with the Personal Data (Privacy) Ordinance (Cap 486), the Company has the right to charge a reasonable fee for processing any data access request.
   5) In the event of any discrepancy or inconsistencies between the English and Chinese versions of this notice, the English version shall prevail.
3. I / We hereby authorize any physician, medical practitioners, hospitals or clinics by whom or where I / We have been observed or treated to give full particulars about my/our health to the Company or its agents.
4. I / We hereby further authorize any parties, including but not limited to police and government authorities, airlines, travel agents, insurance companies etc. who are in possession of my/our insurance proposal information, claim information or any related information to release part or all of the information about the subject or related incidents of injury, loss or damage to the Company or its agents.
5. A photocopy of this authorization shall be considered as effective and valid as the original.

Name of insured person (Name of father or mother of the insured under 18 years old)	Signature of insured person (Signature of father or mother of the insured under 18 years old)
______________________	______________________
HKID / Passport no.	Date of signature
______________________	______________________

Zurich Insurance Company Ltd (a company incorporated in Switzerland)
Claims Department: 26/F, One Island East, 18 Westlands Road, Island East, Hong Kong
Website: www.zurich.com.hk
HealthAngel enquiry: Tel: +852 2903 9382 Fax: +852 2802 6633

Section 3 Employer-approved sick leave certificate (to be completed by claimant's employer)

This certificate is shown as proof of (name of claimant) ______________________________

being the employee of our company (Position) ______________________________

who sustained injury due to (reason(s)) ______________________ happening on (DD/MM/YY) ______________.

This caused him/her to have sick leave period from (DD/MM/YY) ______________to (DD/MM/YY) ______________.

I / our company confirm the monthly salary (excluding bonus, commission, overtime allowance and other allowances) is HKD ______________

Name of employer ______________________ Position of employer ______________________

Address of employer ______________________________

Employer's signature and date

____

Claimant's signature and date

____

(I hereby declare that the above information is true to my fullest understanding)

Company chop

____

Section 4 Attending Physician Statement (This section should be completed by the insured person's attending doctor during patient's hospitalization at the insured person's cost)

第四部份 主診醫生報告 (此欄須由受保人在住院期間之主診醫生填寫，而費用須由受保人負責)

Part I - Treatments Details 甲部 - 醫療資料

Full name of patient 病人姓名 ________________ HKID no. 香港身份證號碼 /Passport no. 護照號碼: _________________ Age 年齡 ________ Sex 性別 ________

(a) Treatment period (DD/MM/YY) 診治日期 (日/月/年) From 由 _________________________________ To 至 _________________________________

(b) Diagnosis of conditions 病況診斷____

(c) Investigations, treatment, therapy, surgical procedures done and result during the above mentioned treatment period 上述診斷期間曾接受之檢查、治療、手術項目及結果：

____

(d) Prior to this consultation, did patient first consult you for the related signs and symptoms? If so, when was the first consultation? 在是次求診日期前，病人有否在您執業之診所治療有關上述病況之紀錄？如有，病人自何時求診？

☐ No 否 ☐ Yes 是, the first consultation was since (DD/MM/YY) 第一次求診日期自 (日/月/年) _________________________________

(e) What sign(s) and symptom(s) was the patient aware of at the first consultation? 病人在第一次求診有什麼主要病徵？

____

(f) Were there any external visible signs of bodily injury were revealed at the first consultation? 傷者在首次求診時，受傷部位有否可見明顯外傷?

____

(g) Was there any evidence of external bruise, wound or abrasion at the first consultation? 傷者在首次求診時，受傷部位表面有否可見之瘀傷、傷口或擦損？ ____

(h) According to the patient, for how long had such symptom(s) persisted before the first consultation? 據病人自述，上述病徵在首次求診前出現多久?

__________ year(s) 年_________ month(s) 月________ day(s) 日

(i) Was the patient referred to you by another doctor for further management? 病人是否由另一位醫生轉介予您在進一步治療?

☐ No 否 ☐ Yes 是, the name of referral doctor is 該醫生姓名是 ____

(j) Was there any hospitalization for the patient? 病人有否住院？

☐ No 否, the patient does not require to stay at hospital for treatment 病人不需要住院接受治療

☐ Yes 有, Hospitalization period from (DD/MM/YY) 住院日期(日/月年) 由 ____________________ to 至 (DD/MM/YY) (日/月年) ____________________

(k) Did the patient have any home leave period during hospitalization period? 病人在住院期間有否請假外出？

☐ No 否 ☐ Yes 有, from (DD/MM/YY) 由 (日/月年) _____________________________ to 至 (DD/MM/YY) (日/月年) _____________________________

(l) Please indicate if the medical condition and its subsequent treatment are associated with the followings: (please ☑)?
請指出上述病況及其後的治療是否與下列情況有關 (請 ☑)?

☐ Congenital anomalies, infertility or sterilization 先天性不正常情況、不育或絕育情況

☐ Dental care, general check up 牙科治療，身體檢查

☐ Under the influence of drugs or alcohol 受藥物或酒精影響

☐ Rest cure, rehabilitation, convalescence or extended car 休養、復康或延續護理

☐ Self-inflicted injuries or suicidal attempt while sane or insane 不論在神智清醒與否下之自我損傷或自殺行為

☐ Mental, psychiatric problems 心理，精神病科

☐ Pregnancy conditions or any related complications 懷孕或由此引發之病況

☐ Cosmetic / Plastic surgery 整形外科手術

Part II – Declaration 乙部 - 聲明

I declare that all the above information are to the best of my knowledge, is true and complete.
本人在以上所有填報資料乃根據本人所知及所信為確實及完全而填報，屬實無訛。

Name of attending doctor 主診醫生姓名 ________________________

Signature of attending doctor 主診醫生簽署 ________________________

Signature Date (DD/MM/YY) 簽署日期 (日/月/年) ________________________

Chop of hospital / clinic 醫院或診所蓋印 ________________________

Address of hospital / clinic 醫院或診所地址 ________________________

Hypertension / Diabetes / Raised Cholesterol Supplementary Claims Form

高血壓/糖尿病/高膽固醇索償附加表

This form should be completed by the insured person's attending doctor during insured person's hospitalization at the insured person's cost
此表格須由受保人在住院期間之主診醫生填寫，而費用須由受保人負責

Part I - Only applicable to patient diagnosed with essential hypertension / Type 2 Diabetes Mellitus / raised cholesterol
甲部 - 此部分只適用於被診斷有原發性高血壓/ 第二型糖尿病/高膽固醇之病人

(a) Full name of patient 病人姓名 ______________________________

(b) The patient is diagnosed with (please ☑) 病人被診斷有 (請 ☑)
☐ Essential hypertension 原發性高血壓 (please also fill in Parts (II), (V) 請填寫第(II) , (V) 部份)
☐ Type 2 Diabetes Mellitus 第二型糖尿病 (please also fill in Parts (III), (V) 請填寫第(III) , (V) 部份)
☐ Dyslipidemia 血脂異常 (please also fill in Parts (VI) , (V) 請填寫第 (VI), (V) 部份)

(c) When was the patient first diagnosed with essential hypertension / Type 2 Diabetes Mellitus / raised cholesterol (DD/MM/YY) 病人何時被初次診斷有原發性高血壓/ 第二型糖尿病/高膽固醇 (日/月/年)
____

(d) What are the medications prescribed? (please provide details including names, dosages and frequency) 處方藥物是什麼？(請提供詳細資料包括藥名，劑量和次數)
____

(e) When was the patient's first consultation with you? (for either related or unrelated conditions) 病人何時第一次向您求診? (無論就相關或不相關情況)
____

(f) Please provide the name and address of the doctors and/or specialists whom this patient has seen in relation to the related conditions
請提供此病人曾經求診的醫生及/或專家的名稱和地址
____

(g) Name of doctor, address of hospital or clinic and date of last consultation by the patient (DD/MM/YY) 病人最近求診的醫生名稱、醫院/診所地址及求診日期(日/月/年)
____

(h) Please provide any additional information that is relevant 請提供您認為相關的其他資料
____

Part II - Only applicable to the patient diagnosed with essential hypertension
乙部 - 以下部份只適用於被診斷有原發性高血壓之病人

(a) What were the BP levels? (Please attach additional paper if necessary) 請列出血壓值（如有需要，請另附紙）

Date (DD/MM/YY) 日期 (日/月/年)	BP 血壓	PR心率

(b) What is the target therapeutic BP level for the management of essential hypertension for this patient? 就管理此病人的原發性高血壓所訂立的目標血壓水平？
____

(c) Are there other cardiovascular risk factors identified? 其他被鑒定的心血管疾病風險因素

☐ Dyslipidaemia 血脂異常 ☐ Diabetes mellitus 糖尿病 ☐ Tobacco use 吸煙
☐ Obesity 肥胖 ☐ Other, please specify 其他，請註明 ______________________________

(d) What is the "10 years CVD risk" score for this patient? 此病人"10 年心血管疾病風險" 的得分 ______________________________

(e) Is there any complication of essential hypertension identified? If "yes", please specify 有否發現高血壓併發症？如有，請註明 ______________________________
____

Part III - Only applicable to the patient diagnosed with Type 2 Diabetes Mellitus
丙部 - 以下部份只適用於被診斷有第二型糖尿病之病人

(a) What were the blood glucose and/or HbA1c levels at the time of first consultation? (Please attach a copy of the results) 第一次應診時的血糖及/或糖化血紅蛋白水平? (請附上結果副本) ______________________________

(b) What were the latest blood glucose and/or HbA1c levels? (Please attach a copy of the results) 最近的血糖及/或糖化血紅蛋白水平? (請附上結果副本)

____

(c) Are these any other diagnostic tests done? (eg OGTT) If yes, please attach a copy of the results. 有否做其他診斷測試(如口服葡萄糖耐受試驗)?如有，請附上結果副本。

____

(d) What is the target HbA1c level of control set for the management of Type 2 Diabetes Mellitus for this patient? 就管理此病人的第二型糖尿所訂立的目標糖化血紅蛋白水平

____

(e) Are there any complications Type 2 Diabetes Mellitus identified? 有否發現第二型糖尿病併發症？

Macrovascular (please specify) 大血管(請註明) ______________________________

Microvascular (please specify) 微血管(請註明) ______________________________

Others (please specify) 其他 (請註明) ______________________________

Part IV - Only applicable to the patient diagnosed with Dyslipidemia
丁部 - 以下部份只適用於被診斷有血脂異常之病人

(a) What was the cholesterol (lipid) level at the time of first consultation? (Please attach a copy of the results) 第一次應診時的膽固醇(血脂)水平? (請附上報告副本)

____

(b) What was the latest cholesterol (lipid) level? (Please attach a copy of the results) 最近的膽固醇(血脂)水平 (請附上結果副本)

____

(c) What is the clinical guideline adopted for the management of Dyslipidemia in this patient? 採用了什麼臨床指引去控制該血脂異常的病人？

☐ NCEP ATP III ☐ NCEP ATP IV ☐ Other (Please specify) 其他，請註明 ______________________________

(d) Are there other cardiovascular risk factors identified? 其他被鑒定的心血管疾病風險因素

☐ Hypertension 高血壓 ☐ Diabetes Mellitus 糖尿病 ☐ Tobacco use 吸煙
☐ Obesity 肥胖 ☐ Other, please specify 其他，請註明 ______________________________

(e) What is the “10 years CVD risk” score for this patient? 此病人”10 年心血管疾病風險” 的得分 ______________________________

Part V – Declaration
戊部 - 聲明

I declare that all the above information is true and complete to the best of my knowledge and belief.
本人在以上所有填報資料乃根據本人所知及所信為確實及完全而填報，屬實無訛。

Name of attending doctor 主診醫生姓名 ____________________

Signature of attending doctor 主診醫生簽署 ____________________

Signature Date (DD/MM/YY) 簽署日期 (日/月/年) ____________________

Chop of hospital / clinic 醫院或診所蓋印 ____________________

Address of hospital / clinic 醫院或診所地址 ____________________

Zurich Insurance Company Ltd (a company incorporated in Switzerland) 蘇黎世保險有限公司 (於瑞士註冊成立之公司)
Claims Department: 26/F, One Island East, 18 Westlands Road, Island East, Hong Kong 理賠部：香港港島東華蘭路 18 號港島東中心 26 樓
HealthAngel enquiry「三高保」查詢 Tel 電話：+852 2903 9382 Fax 傳真：+852 2802 6633 網址：www.zurich.com.hk